

## 11987 CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <b>Howard Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waterloo Jessup R.F.D. - 3 yrs.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waterloo Jessup R.F.D. x2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ceder Ave.</b>				d. STREET ADDRESS <b>Rt. 1 Box 262</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ADAMS</b> Last				4. DATE OF DEATH Month <b>NOV.</b> Day <b>3,</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 10, 1891</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ceder Creek N. C.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Promise Adams</b>				14. MOTHER'S MAIDEN NAME <b>Eliza ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Bessie Adams Rt. 1, Box 262</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive - Cardio Vascular Disease</b> <b>443X</b> DUE TO <b>Acute Congestive Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>- 6 mos.</b> (c) <b>- 1 month.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 3<sup>rd</sup> 1957</b> to <b>Nov. 3<sup>rd</sup> 1957</b> , that I last saw the deceased alive on <b>Nov. 3<sup>rd</sup> 1957</b> , and that death occurred at <b>10 - M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Savage, Md.</b> DATE SIGNED <b>11/5/57</b>							
ACTUAL SIGNATURE <b>Shank &amp; Shiley</b> M.D.				PHYSICIAN'S NAME (Type) <b>Frank E. Shiley</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 7, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Ceder Hill Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Miss Kathie R. Williams</b> ADDRESS <b>322 N. Schomberg St.</b>				24a. REC'D BY REGISTRAR <b>DATE 11/7/57</b>		24b. REGISTRAR'S SIGNATURE <b>E. Bird Williams</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

1957 8 NOV

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11988

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11997

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Howard</b> b. COUNTY <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. LENGTH OF STAY IN 1b <b>XO</b> <b>Elkridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HAMMOND COLLINS</b>		4. DATE OF DEATH Month Day Year <b>November 12, 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1904</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harry Lee Collins</b>		14. MOTHER'S MAIDEN NAME <b>Ida J. Dixon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Thomas L. Collins, Elkridge, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Alcoholism</b> <b>581.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fatty Infiltration of Liver</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>322.1</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>11/12/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-15-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>NOV 14 1957</b>		24b. REGISTRAR'S SIGNATURE <b>E. Bird Williams</b>	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
BALTIMORE

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NOV 14 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11989 CERTIFICATE OF DEATH

11998

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Simons Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Glenelg</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>E</b> Last <b>DAY</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-1875</b>		9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Carroll Mullinix, Glenelg, Md</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/1</b> , 19 <b>57</b> , to <b>11/15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/14</b> , 19 <b>57</b> , and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Charles S. Whitaker</b> ADDRESS (Street, city or town, state) <b>CLARKSVILLE, MD.</b> DATE SIGNED <b>11/16/57</b> PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-18-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Alpha, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>NOV 18 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Whitaker</b>			



7001. 11. 19. 1955

**BUREAU V. S.**

NOV 18 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11990

Items 13, 14, Film G222 11-12-57 et

## CERTIFICATE OF DEATH

11999

Reg. Dist. No.

194

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. LENGTH OF STAY IN 1b <u>Baltimore (22)</u> <u>0353.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Taylor Manor Hospital</u>				d. STREET ADDRESS <u>8244 Northview Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>---</u> Last <u>Litzenburg</u>				4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1874</u>		9. AGE (In years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>6</u> Min. <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O employee</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>Hiram L. Litzenburg</u>				14. MOTHER'S MAIDEN NAME <u>Georgianna Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. &amp; Mrs. Joseph P. Jacob</u> Address <u>8244 Northview Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis due to cerebral Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, <u>19</u> Day, <u>19</u> Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug. 27 th 19 57</u> to <u>Nov. 5 19 57</u> , that I last saw the deceased alive on <u>Nov. 5 19 57</u> , and that death occurred at <u>6:20 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irving J. Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>Taylor Manor Hospital</u>		DATE SIGNED <u>11/5/57</u>	
PHYSICIAN'S NAME (Type) <u>Irving J. Taylor</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-7-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stein Funeral Home</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 6 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Loughran</u>			

CERTIFICATE OF DEATH

Page One

Name of Deceased <b>John</b>		Sex <b>Male</b>		Age <b>65</b>	
Date of Birth <b>Nov 1929</b>		Place of Birth <b>England</b>		Race <b>White</b>	
Usual Residence <b>1234 North Ave</b>		Cause of Death <b>Chronic Myocardial Degeneration</b>		Manner of Death <b>Natural</b>	
Occupation <b>Employee</b>		Date of Death <b>Nov 1957</b>		Place of Death <b>Home</b>	
Signature of Physician <b>[Signature]</b>		Signature of Registrar <b>[Signature]</b>		Date of Registration <b>Nov 1957</b>	

Medical History <b>Chronic Myocardial Degeneration</b>		Date of Onset <b>1950</b>	
Symptoms <b>Chronic Arteriosclerosis</b>		Date of Onset <b>1950</b>	
Diagnosis <b>Chronic Arteriosclerosis</b>		Date of Onset <b>1950</b>	
Treatment <b>Ischemia due to cerebral arteriosclerosis</b>		Date of Onset <b>1950</b>	
Prognosis <b>Ischemia due to cerebral arteriosclerosis</b>		Date of Onset <b>1950</b>	

BUREAU V. B.		NOV 6 1957	
RECEIVED		NOV 1957	
Taylor Manor Hospital		NOV 1957	
One Hall		NOV 1957	
Date		NOV 1957	



11991

CERTIFICATE OF DEATH

12000

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
c. LENGTH OF STAY IN 1b <u>6 mo</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ramsey Drive - Howard Heights</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>Ramsey Drive</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER-JOSEPH-MELZER</u>		4. DATE OF DEATH <u>Nov. 15 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 22 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cars-Lowrey Sales</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank C. Melzer</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Reiber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-106659</u>	
17. INFORMANT <u>Pearl M. Heidicker</u>		Address <u>Ramsey Drive St. E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Coronary Artery Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>2 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 15 1953</u> to <u>Nov. 15 1957</u> , that I last saw the deceased alive on <u>Nov. 1 1957</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>J. Nelson McKay</u>		M.D. <u>6014 Edmondson Ave Balto 28 MD 11-16-57</u>	
PHYSICIAN'S NAME (Type) <u>J. Nelson McKay, M.D.</u>		<u>6014 Edmondson Ave. Balto. 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 19 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Penfel</u>		24. REC'D BY REGISTRAR <u>NOV 18 1957</u>	
ADDRESS <u>5311 Edmondson Ave</u>		24b. REGISTRAR'S SIGNATURE <u>J. Loughery</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

File No. 100

NAME OF DECEASED		DATE OF DEATH	
WALTER JOSEPH		NOV 18 1957	
AGE		SEX	
45		M	
RACE		OCCUPATION	
W		C	
BIRTHPLACE		PLACE OF BIRTH	
I		I	
MARRIED		CAUSE OF DEATH	
Y		I	
PREVIOUS ILLNESS		MANNER OF DEATH	
N		N	
PLACE OF DEATH		DATE OF BURIAL	
H		N	
BURIAL PLACE		DATE OF INTERMENT	
H		N	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF CORONER		SIGNATURE OF JUDGE	

BUREAU V. S.

NOV 18 1957

RECEIVED

11992

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG223 11-27-57 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

## 1. PLACE OF DEATH

a. COUNTY

Howard

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Howard

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

COOKSVILLE

c. LENGTH OF STAY IN 1b

LIFE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X2 COOKSVILLE

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒3. NAME OF  
DECEASED  
(Type or print)

First

ERNEST

Middle

SYLVESTER

Last

MILES

4. DATE  
OF  
DEATH

Month

November

Day

15,

Year

1957

## 5. SEX

Male

## 6. COLOR OR RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

## 8. DATE OF BIRTH

October 17, 1895

9. AGE (in years  
last birthday)

62 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Howard Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Oliver Scott Miles

## 14. MOTHER'S MAIDEN NAME

DEBORAH LOCKMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

219-28-8339

17. INFORMANT

Address

Katie Miles, Cooksville, Md.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Arteriosclerotic Cardiovascular Disease

422.1

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a. m.  
p. m.

19

20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL  
SIGNATURE

William V. Lovitt, Jr.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

11/15/57

EXAMINER'S  
NAME (Type)

William V. Lovitt, Jr., M.D.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

11-20-57

22c. NAME OF CEMETERY OR CREMATORY

Bushy Park

22d. LOCATION (City, town, or county)

Cooksville, Howard, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Arthur A. Haight

ADDRESS

Cookeville, Md.

24a. REC'D BY REGISTRAR

NOV 21 1957

24b. REGISTRAR'S SIGNATURE

O. Searcy

RECEIVED  
NOV 21 1957  
BUREAU V. 3

NOV 21 1957

11993

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>5 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Taylor Manor Hospital</b>				d. STREET ADDRESS <b>Marlin House Hotel</b>			
3. NAME OF DECEASED (Type or print) First <b>Estelle</b> Middle <b>Robinson</b> Last				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 20, 1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>29</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Greenville, S. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Robinson</b>				14. MOTHER'S MAIDEN NAME <b>Selena Glanze</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Arthur U. Hooper, 100 St. Paul St., 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>45a0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO <b>Arteriosclerosis, generalized, severe</b> (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis; decubitus ulcers; varicose ulcers</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>June 20, 1957</b> to <b>Nov 18, 1957</b> , that I last saw the deceased alive on <b>Nov 18, 1957</b> , and that death occurred at <b>8 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stephen Lee Magness, M.D. Taylor Manor Hospital, 11/18/57</b>							
ACTUAL SIGNATURE <b>Stephen Lee Magness</b>				PHYSICIAN'S NAME (Type) <b>Stephen Lee Magness; M.D. Ellicott City, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b>				24a. REC'D BY REGISTRAR <b>NOV 25 1957</b>		24b. REGISTRAR'S SIGNATURE <b>E. Dougherty</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

12003

11994

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21, Md.</b> <b>0354.2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Taylor Manor Hospital</b>		d. STREET ADDRESS <b>218 St. Mary's Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Rosenthal</b> Last <b>Rosenthal</b>		4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-28-1893</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Retail</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE - Md</b>	11. BIRTHPLACE (State or foreign country) <b>USA</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13. FATHER'S NAME <b>FREDERICK W. ROSENTHAL</b>	14. MOTHER'S MAIDEN NAME <b>IDEL</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>217-9-0084</b>	16. SOCIAL SECURITY NO. <b>MRS. KATHRYN M. ROSENTHAL</b>	17. INFORMANT <b>MRS. KATHRYN M. ROSENTHAL</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial failure</b> DUE TO <b>2 hrs.</b> (c) <b>Arteriosclerotic cardiovascular disease</b> <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome with senile brain disease with behavioral reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>Oct 23</b> , 1957, to <b>Nov 30</b> , 1957, that I last saw the deceased alive on <b>Nov 30</b> , 1957, and that death occurred at <b>2:00 P.</b> from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <b>11/30/57</b>	

ACTUAL SIGNATURE <b>Stephen Lee Magness</b>	M.D. <b>Taylor Manor Hospital, Ellicott City Md</b>
PHYSICIAN'S NAME (Type) <b>Stephen Lee Magness, M.D.</b>	<b>Taylor Manor Hospital, Ellicott City Md</b>

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-4-57</b>	22b. DATE THEREOF <b>12-4-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck</b>	ADDRESS <b>1305 Bayford</b>	24a. REC'D BY REGISTRAR <b>DEC 4 1957</b>	24b. REGISTRAR'S SIGNATURE <b>J. C. Dougherty</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NAME OF DECEASED <b>Howard</b>		DATE OF BIRTH <b>1911</b>	
PLACE OF BIRTH <b>Elliot City</b>		DATE OF DEATH <b>30 days</b>	
PLACE OF DEATH <b>Taylor Manor Hospital</b>		DATE OF DEATH <b>November 30</b>	
RESIDENCE <b>218 S. Mary's Road</b>		CITY <b>Baltimore, Md.</b>	
OCCUPATION <b>Rosemanal</b>		CAUSE OF DEATH <b>27</b>	

DISEASE <b>Chronic brain syndrome with senile brain disease with behavioral reaction</b>	
DISEASE <b>Arteriosclerotic cardiovascular disease</b>	
DISEASE <b>Myocardial infarct</b>	
DISEASE <b>Pulmonary edema</b>	
DISEASE <b>2 hrs.</b>	
DISEASE <b>2 hrs.</b>	
DISEASE <b>UNKNOWN</b>	

**RECEIVED**  
DEC 4 1957  
BUREAU V. S.

DATE OF DEATH <b>NOV 30</b>		TIME OF DEATH <b>5:00</b>	
DATE OF DEATH <b>NOV 30</b>		TIME OF DEATH <b>5:00</b>	
DATE OF DEATH <b>NOV 30</b>		TIME OF DEATH <b>5:00</b>	
DATE OF DEATH <b>NOV 30</b>		TIME OF DEATH <b>5:00</b>	
DATE OF DEATH <b>NOV 30</b>		TIME OF DEATH <b>5:00</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11995

## CERTIFICATE OF DEATH

Reg. Dist. No.

12004

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenelg</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tridelphia Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNIE</u> First <u>ELIZABETH</u> Middle <u>SELBY</u> Last				4. DATE OF DEATH <u>Nov.</u> Month <u>8</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6 1868</u>		9. AGE (In years last birthday) yrs. <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jonathan Musgrove</u>				14. MOTHER'S MAIDEN NAME <u>Susan Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>William O. Selby</u> Address <u>Glenelg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>446X</u> IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO (b) <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ DUE TO _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July, 1940</u> , to <u>Nov. 8</u> , 1957, that I last saw the deceased alive on <u>Nov. 4</u> , 1957, and that death occurred at <u>9:00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) <u>Clarksville, Maryland</u> DATE SIGNED <u>11/8/57</u>			
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		22d. LOCATION (City, town, or county) (State) <u>Alpha Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>				24a. REC'D BY REGISTRAR <u>NOV 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Maria Whitaker</u>	

RECEIVED

NOV 12 1957

BUREAU V. S.

1. NAME OF DECEASED		2. DATE OF DEATH		3. PLACE OF DEATH	
4. SEX		5. AGE		6. OCCUPATION	
7. MARITAL STATUS		8. EDUCATION		9. RELIGION	
10. RACE		11. ETHNIC ORIGIN		12. SOCIAL SECURITY NUMBER	
13. BIRTH DATE		14. BIRTH PLACE		15. BIRTH COUNTRY	
16. DECEASED'S SIGNATURE		17. DECEASED'S ADDRESS		18. DECEASED'S CITY	
19. DECEASED'S STATE		20. DECEASED'S ZIP CODE		21. DECEASED'S COUNTRY	
22. DECEASED'S PHONE NUMBER		23. DECEASED'S FAX NUMBER		24. DECEASED'S E-MAIL ADDRESS	
25. DECEASED'S WEBSITE		26. DECEASED'S BLOG		27. DECEASED'S SOCIAL MEDIA	
28. DECEASED'S GALLERY		29. DECEASED'S VIDEO		30. DECEASED'S AUDIO	
31. DECEASED'S DOCUMENTS		32. DECEASED'S IMAGES		33. DECEASED'S VIDEOS	
34. DECEASED'S AUDIO		35. DECEASED'S VIDEO		36. DECEASED'S DOCUMENTS	
37. DECEASED'S IMAGES		38. DECEASED'S VIDEOS		39. DECEASED'S AUDIO	
40. DECEASED'S DOCUMENTS		41. DECEASED'S IMAGES		42. DECEASED'S VIDEOS	
43. DECEASED'S AUDIO		44. DECEASED'S VIDEO		45. DECEASED'S DOCUMENTS	
46. DECEASED'S IMAGES		47. DECEASED'S VIDEOS		48. DECEASED'S AUDIO	
49. DECEASED'S DOCUMENTS		50. DECEASED'S IMAGES		51. DECEASED'S VIDEOS	
52. DECEASED'S AUDIO		53. DECEASED'S VIDEO		54. DECEASED'S DOCUMENTS	
55. DECEASED'S IMAGES		56. DECEASED'S VIDEOS		57. DECEASED'S AUDIO	
58. DECEASED'S DOCUMENTS		59. DECEASED'S IMAGES		60. DECEASED'S VIDEOS	
61. DECEASED'S AUDIO		62. DECEASED'S VIDEO		63. DECEASED'S DOCUMENTS	
64. DECEASED'S IMAGES		65. DECEASED'S VIDEOS		66. DECEASED'S AUDIO	
67. DECEASED'S DOCUMENTS		68. DECEASED'S IMAGES		69. DECEASED'S VIDEOS	
70. DECEASED'S AUDIO		71. DECEASED'S VIDEO		72. DECEASED'S DOCUMENTS	
73. DECEASED'S IMAGES		74. DECEASED'S VIDEOS		75. DECEASED'S AUDIO	
76. DECEASED'S DOCUMENTS		77. DECEASED'S IMAGES		78. DECEASED'S VIDEOS	
79. DECEASED'S AUDIO		80. DECEASED'S VIDEO		81. DECEASED'S DOCUMENTS	
82. DECEASED'S IMAGES		83. DECEASED'S VIDEOS		84. DECEASED'S AUDIO	
85. DECEASED'S DOCUMENTS		86. DECEASED'S IMAGES		87. DECEASED'S VIDEOS	
88. DECEASED'S AUDIO		89. DECEASED'S VIDEO		90. DECEASED'S DOCUMENTS	
91. DECEASED'S IMAGES		92. DECEASED'S VIDEOS		93. DECEASED'S AUDIO	
94. DECEASED'S DOCUMENTS		95. DECEASED'S IMAGES		96. DECEASED'S VIDEOS	
97. DECEASED'S AUDIO		98. DECEASED'S VIDEO		99. DECEASED'S DOCUMENTS	
100. DECEASED'S IMAGES		101. DECEASED'S VIDEOS		102. DECEASED'S AUDIO	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - CALVERT 095 18



11996

12005

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>10 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Engene</b> Last <b>Selby</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-1882</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motorman retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Trans.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Franklin E. Selby</b>				14. MOTHER'S MAIDEN NAME <b>Ida Ann Blacksten</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>215-09-3851</b>		17. INFORMANT <b>Mrs. Agnes Dorsey,</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest, Coronary Thrombosis</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis, generalized</b> DUE TO (c) <b>arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>186 to Nov 1957</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1956</b> , 19 <b>Nov</b> , to <b>Nov</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>23 Nov</b> , 19 <b>57</b> , and that death occurred at <b>1:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Howard E. Hall</b> M.D.				ADDRESS (Street, city or town, state) <b>Appl. Md</b> DATE SIGNED <b>23 Nov 57</b>			
PHYSICIAN'S NAME (Type) <b>HOWARD E. HALL</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-26-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pipe Creek</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b> ADDRESS <b>Winfield, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 26 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

Form 100-100

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Nov 26 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. SIGNATURE OF DECEASED <i>John J. Smith</i>	
16. SIGNATURE OF WITNESS <i>John J. Smith</i>		17. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		18. SIGNATURE OF CORONER <i>John J. Smith</i>	
19. SIGNATURE OF DECEASED <i>John J. Smith</i>		20. SIGNATURE OF WITNESS <i>John J. Smith</i>		21. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>	
22. SIGNATURE OF CORONER <i>John J. Smith</i>		23. SIGNATURE OF DECEASED <i>John J. Smith</i>		24. SIGNATURE OF WITNESS <i>John J. Smith</i>	
25. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		26. SIGNATURE OF CORONER <i>John J. Smith</i>		27. SIGNATURE OF DECEASED <i>John J. Smith</i>	
28. SIGNATURE OF WITNESS <i>John J. Smith</i>		29. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		30. SIGNATURE OF CORONER <i>John J. Smith</i>	
31. SIGNATURE OF DECEASED <i>John J. Smith</i>		32. SIGNATURE OF WITNESS <i>John J. Smith</i>		33. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>	
34. SIGNATURE OF CORONER <i>John J. Smith</i>		35. SIGNATURE OF DECEASED <i>John J. Smith</i>		36. SIGNATURE OF WITNESS <i>John J. Smith</i>	
37. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		38. SIGNATURE OF CORONER <i>John J. Smith</i>		39. SIGNATURE OF DECEASED <i>John J. Smith</i>	
40. SIGNATURE OF WITNESS <i>John J. Smith</i>		41. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		42. SIGNATURE OF CORONER <i>John J. Smith</i>	
43. SIGNATURE OF DECEASED <i>John J. Smith</i>		44. SIGNATURE OF WITNESS <i>John J. Smith</i>		45. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>	
46. SIGNATURE OF CORONER <i>John J. Smith</i>		47. SIGNATURE OF DECEASED <i>John J. Smith</i>		48. SIGNATURE OF WITNESS <i>John J. Smith</i>	
49. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		50. SIGNATURE OF CORONER <i>John J. Smith</i>		51. SIGNATURE OF DECEASED <i>John J. Smith</i>	
52. SIGNATURE OF WITNESS <i>John J. Smith</i>		53. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		54. SIGNATURE OF CORONER <i>John J. Smith</i>	
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58. SIGNATURE OF CORONER <i>John J. Smith</i>		59. SIGNATURE OF DECEASED <i>John J. Smith</i>		60. SIGNATURE OF WITNESS <i>John J. Smith</i>	
61. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		62. SIGNATURE OF CORONER <i>John J. Smith</i>		63. SIGNATURE OF DECEASED <i>John J. Smith</i>	
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100. SIGNATURE OF WITNESS <i>John J. Smith</i>		101. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>		102. SIGNATURE OF CORONER <i>John J. Smith</i>	

BUREAU V. E.

NOV 26 1957

RECEIVED